

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034905

FILED VS OCT 1 0 1960

Registration District No.

149

Primary Registration District No.

1002

Registrar's No.

4875

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH

a. COUNTY

Jackson

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN

Kansas City

Length of stay in 1b

45 days

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION

Allbritton Nursing Home

Inside Limits

Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Kansas

b. COUNTY

Wyandotte

c. CITY OR TOWN

Kansas City

Inside Limits

Yes ☐ No ☐

d. STREET ADDRESS

1017 Walker st.

Reside on Farm

Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)

First

Mary

Middle

Magdaline

Last

Maxwell

4. DATE OF DEATH

Month

9

Day

23

Year

1960

5. SEX

Female

6. COLOR OR RACE

Negro

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH

8/24/1909

9. AGE (last birthday)

51

10. IF UNDER 1 YEAR

Months

Days

11. IF UNDER 24 HR

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House Wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

Shreveport, La.

12. CITIZEN OF WHAT COUNTRY

U. S. A.

13a. FATHER'S NAME

Joshua Rowens

13b. MOTHER'S MAIDEN NAME

Penny Ross

14. NAME OF HUSBAND OR WIFE

Adolphus Maxwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Address

John Gardner 1027 Walker st. K. C. Kans.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Carcinoma of the Larynx

INTERVAL BETWEEN ONSET AND DEATH

5 wks

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT SUICIDE HOMICIDE

neither

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

none

20c. TIME OF INJURY
Hour
and
p.m.

Month, Day, Year

none

20d. INJURY OCCURRED WHILE AT WORK ☐
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

none

20f. CITY, TOWN, OR LOCATION

Kansas City, Jackson, Mo

21. I attended the deceased from 17 Aug 60 to 23 Sept 60. I last saw him alive on 23 Sept 60.

Death occurred at 4:10 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

John H. Wells MD

22b. ADDRESS

3718 Prospect

22c. DATE SIGNED

9/26/60

23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

23b. DATE

9-27-60

23c. NAME OF CEMETERY OR CREMATORY

West Lawn

23d. LOCATION (City, town, or county)

Kansas City, Kans.

24. FUNERAL DIRECTOR

ADDRESS

Mrs. J. W. Jones 440 state ave. Kans.

25. DATE RECD. BY LOCAL REG.

9-27-60

26. REGISTRAR'S SIGNATURE

H. L. Dwyer

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

JOHN H. WELLS, MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Angela English

Licensed Embalmer No. *44109*

P. O. Address *4400 State*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.